

# Disabled Athlete Emergency Protocol Consent Form

## Athlete Information

Full Name

Date of Birth

Type of Disability

Team/Organization

## Emergency Contacts

Contact Name

Relationship

Phone Number

Contact Name

Relationship

Phone Number

## Medical Information

Primary Physician Name

Physician Phone Number

Current Medications

Allergies

Emergency Care Protocols & Accessibility Needs

## Consent and Authorization

☐

I authorize medical personnel to provide emergency treatment as deemed necessary.

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I consent to emergency transport if required.

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I permit sharing of this information with relevant event staff and medical personnel.

Signature

Date